



**Figure 3.** Passive mobilization in internal rotation with physiotherapist (3A), or in self-rehabilitation with a stick (3B), or with the contralateral hand (3C).

1 proximal humeral fractures. Regular passive mobilization is  
 2 also a cornerstone in the treatment of painful, stiff shoulders,  
 3 and adhesive capsulitis.

4 Each session begins with a massage followed by a warm-up  
 5 with pendulum exercises, called “Shoulder Aspirin” by DFG in  
 6 the 1990’ (Figure 1A). A 2-kilogram weight is sometimes used  
 7 to passively distract the shoulder.

8 Passive flexion with the physical therapist, in a lying posi-  
 9 tion on the back, knees bent. After a “pumping” (Figure 1B) of  
 10 analgesic decoaptation of the shoulder, the physiotherapist  
 11 exerts strong traction on the arm until complete passive flexion

is obtained (Figures 1C–1D). The same type of exercise is per-  
 12 formed by the patient alone, in self-rehabilitation, 3–4 times a  
 13 day (Figures 1E–1H). For the return to be painless, the elbow  
 14 must be kept extended and the hand on the affected side must  
 15 fight forcefully against the resistance of the hand on the healthy  
 16 side (Figures 1G, 1H).  
 17

- Self-rehabilitation of passive flexion can also be done with  
 18 a stick (Figures 2A–2D), as external rotation (Figure 2E). 19
- Passive external rotation is performed with the physio-  
 20 therapist, lying on the back, knees bent, in slight abduc- 21